Initial Report of Findings for the Commission to Study Certificate of Need in Georgia Long Term Care Sub-Committee

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State Classifications for Nursing Home Analysis

	CON Regulation of Nursing Homes	No CON
Absolute Moratorium on all new LTC Beds	Florida Maine Massachusetts Washington West Virginia	Wisconsin Utah
Limited additional beds possible	Georgia Iowa Oregon[1]	Colorado

State Classifications for Home Health Analysis

CON States	Non-CON States
Georgia Iowa Washington West Virginia	Colorado Florida Maine Massachusetts Oregon Utah Wisconsin

[1] Oregon operates under a policy that considers nursing homes to be the placement of last resort. The state has also placed great emphasis on developing alternative living arrangements, such as assisted living facilities and adult foster homes. (Oregon's Medicaid program pays for care in these alternate settings.) These strategies resulted in a drop in the ratio of nursing home beds per 1,000 older persons from 47 in 1982, to 36 in 1992, one of the lowest ratios in the country.

Market Structure: Nursing Homes

	Number of Facilities	Licensed Beds per 1,000 elderly	Occupancy Rate	Mean Herfindahl
All Study States	3282	42.05	85.7	2,436
Moratorium States				
Florida	680	28.4	88.4	1,185
Maine	113	38.94	89.8	969
Massachusetts	456	57.44	89.9	101
Utah	93	39.54	72.1	1,694
Washington	246	32.43	85.9	1,680
West Virginia	131	39.68	90.1	1,242
Wisconsin	398	53.51	87.1	1,496
All Moratorium States	**2,117**	**36.33**	**87.67**	**1,879**
Limited Restriction States				
Colorado	212	46.6	82.3	3,671
Georgia	359	48.49	90	3,497
Iowa	455	76.07	81.3	2,221
Oregon	139	27.69	66	4,508
All Limited Restriction States	**1165**	**49.33**	**82.34**	**3,256**
CON states	703	**40.2**	**86.4**	2,274
Non-CON states (WI, CO, UT)	2579	**51.3**	**83.7**	2,436

Summary of Findings

The following table summarizes the findings regarding the effect of market restrictions and CON on nursing homes.

	Finding	
Access / Market Structure	**Moratorium**	**CON**
Beds Per 1,000 residents	Decreases	No effect
Occupancy Rate	Increases (++)	Increases
Competition (inverse Herfindahl)	Increases (++)	Increases
Case mix adjustment[2]	Increases	Increases
Quality		
Staffing per patient day	Increases	Increases
Outcome Measures (results shown control for case mix)		
Share of high-risk patients with pressure sores	No effect	Increases
Share of residents more depressed or anxious	No effect	Increases
Share of residents with a catheter	No effect	Decreases
Share of residents with UTI	No effect	Increases
Share of residents with Delirium	Decreases	No effect
Share of short stay residents with moderate to severe pain	No effect	Decreases
Share of short stay residents with pressure sores	No effect	Increases
Index: Likelihood of scoring in worse decile across all measures	No effect	Increases – if no case mix adjustment No effect – with case mix adjustment
Reporting	No effect	No effect
Costs		
Medicaid costs per patient day	Increases	Increases
Medicare costs per patient day	No effect	No effect
Private sector costs per patient day	Increases	Increases
Medicaid cost growth rate	Increases	No effect
Per capita growth rate	No effect	No effect

[2] Patient Acuity is measured as the sum of the share of patients whose ADLs are declining, the share of patients with inadequate bowel/bladder control, the share of patients spending most of the time in a bed or chair, and the share of patients whose ability to move around their room decreased.

Market Structure: Home Health

	Home Health Agencies	Agencies per 1,000 Elderly	Share Offering Full Service	Average Herfindahl
All Study States	1545	0.190	70.2%	4,608
CON States	**395**	**0.178**	60.8%	**5,437**
Georgia	95	0.116	82.1%	6,925
Iowa	179	0.409	44.1%	4,687
Washington	59	0.085	89.8%	4,588
West Virginia	62	0.226	48.4%	3,339
Non-CON states	**1,150**	**0.194**	73.5%	**3,862**
Colorado	139	0.326	71.2%	4,950
Florida	631	0.206	74.6%	1,744
Maine	29	0.153	86.2%	3,542
Massachusetts	116	0.133	85.3%	209
Oregon	60	0.132	75.0%	5,685
Utah	53	0.269	90.6%	2,406
Wisconsin	122	0.170	47.5%	4,741

Summary of Findings

The following table summarizes the findings regarding the effect of CON on home health.

	CON Effect
Access / Market Structure	
Agencies Per 1,000 residents	Decreases
Competition (inverse Herfindahl)	Decreases
Share of Agencies with full service line	No effect
Medicare beneficiaries receiving Home Health Services	Decreases
Quality	
Outcome Measures - share paticnts with good outcomes	No effect
Outcome Measures – share of measures on which the facility measures in the lowest (best) decile	No effect
Reporting – likelihood that an agency will report all scores	Increases
Costs	
Medicare costs per patient day	No effect
Private sector costs per patient day	No effect
Medicaid cost growth rate	Increases
Medicaid per capita growth rate	Increases

Georgia Association of Homes & Services for the Aging

GAHSA PUBLIC COMMENT TO LONG TERM CARE COMMITTEE OF THE COMMISSION ON THE EFFICACY OF THE CON PROGRAM: 10/3/06

The Georgia Association of Homes and Services for the Aging (GAHSA) is an association representing a diverse group of non-profit senior care providers with distinct constituent groups: retirement communities, nursing homes, low-income senior and retirement housing, assisted living, hospital-based and community-based providers. We appreciate the opportunity to offer these brief comments to the CON Commission Long Term Care Services Committee concerning Continuing Care Retirement Communities (CCRCs).

CCRCs have emerged as an important option in the continuum of residential services for seniors. They offer an innovative and independent lifestyle that is different from other housing and care options for older adults. Through long-term contracts that provide for housing, services and nursing care, usually all in one location, the CCRC continues to meet residents' needs in a familiar setting as they grow older. While they need not be the subjects of future legislation, the following are major points about the regulation of CCRCs of which GAHSA would like to make the LTC Committee aware:

- There is a need to allow Continuing Care Retirement Communities to admit nonresidents directly into their nursing facilities for a time period until residents in the CCRC have "aged in place" and are in need of nursing home services. Despite the fact that CCRCs must build the nursing home component in the initial development, residents of a new CCRC will not fully occupy the nursing facility beds until the CCRC is 7 to 9 years in operation. Direct admittance into the nursing facility will offset the large costs incurred in operating the nursing facility and, in turn, maintain lower monthly service fees paid by CCRC residents.

- The CON process requires that a CCRC begin construction within twelve months of receiving their CON. This logic is more reflective of building a freestanding nursing facility. For the development of a CCRC project, certain pre-sales must be met before construction can begin. Pre-sale goals vary depending on long-term financing requirements and Certificate of Authority regulatory requirements, but typically run around 60 to 70 percent of the CCRC residences being reserved in advance. For these reasons a 12-month timeframe is not feasible for a CCRC project, and GAHSA recommends that a 36-month timeframe be adopted.

- The current ratio of nursing home beds to independent living units in CCRCs is 1:5. Providing more flexibility in this ratio will allow assist seniors in CCRCs to "age in place and for CCRCs to meet the needs of the community.

- The requirement that personal care homes (assisted living) provide 1% indigent care is somewhat inconsistent with the population generally served by CCRCs and the financial factors required by the Department of Insurance in the application for a Certificate of Authority. Perhaps allowing CCRCs to meet this requirement through community outreach (giving back to the community) could be considered.

- The Department of Community Health has discretion in deciding which costs to include when determining the amount of expenditures projected for a project and whether those expenditures trigger the $350,000 threshold for CON review. The DCH practice of including all costs is detrimental to organizations-most of which are nonprofit entities- when renovating a CCRC facility. If DCH were more flexible in such cases, the fee for DCH analysis would be substantially less (e.g. $20,000 instead of $50,000), a difference of importance to CCRCs and their residents, who ultimately shoulder the financial burden.

- Currently the CON application process is separate for assisted living (personal care homes) and nursing facilities. A single application for CCRCs would significantly simplify the CON process.

- Research has shown that Georgia is fertile ground for further development of both CCRCs and other types of retirement communities. The need for additional residential options for older Georgians will grow, and CCRCs will be one of the options developed to provide an additional part of the continuum of services for seniors. The sometimes conflicting regulatory aims of DCH and the Department of Insurance, from whom a CCRC must obtain a Certificate of Authority to operate, create an environment which is neither compatible with assuring quality of care for residents nor a good regulatory and economic environment in which service providers can operate.